

**Selective Mutism: A Misunderstood Beast**

**An Honors Thesis (HONR 499)**

**by**

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April, 2016

**Expected Date of Graduation**

May, 2016

Abstract: The purpose of this paper is to inform the reader about selective mutism, an early childhood communicative disorder in which the child is unable to communicate effectively in specific environments, but in other environments communication the individual is able to communicate normally. This paper encourages early diagnosis and highlights the benefits of early intervention for the disorder. It explores three different types of treatment methods including; behavioral and cognitive-behavioral therapy, medication, and individual psychotherapy as well as providing a brief history of the diagnosis. Further research is needed to better define its cause/s, investigate the effectiveness of the current treatment methods, and develop accurate testing methods to better identify individuals with the disorder.

#### Acknowledgements

I would like to thank Dr. Julie Griffith for her assistance with this daunting task and continually keeping me on pace. Her help with this thesis was only a small portion of the help and support I have received during my time at Ball State University.

### Selective Mutism: A Misunderstood Beast

Sofia sits at her desk dreading the moment when her first grade teacher will call her to the front of the room for show and tell. "Sofia," her teacher calls, "come on up and tell us about what you've brought to class." Sofia freezes in her seat unable to move as all sixteen of her classmates watch her expectantly. Her teacher instructs her more firmly this time, but she remains motionless in her seat, after a couple more attempts the teacher gives up and returns to his desk where he writes the same note he writes every week for her parents. The note reads "Sofia was once again unwilling to participate in classroom activities." Her teacher continually becomes more frustrated with Sofia's defiant behavior, as everyday he watches her talk with classmates, but she has yet to utter one word to him in the six months he has been her teacher.

Upon returning home, Sofia sits down at her kitchen counter to begin working on her math homework. Her babysitter of five years enters the room and questions her about her day at school as she does every day, only to have Sofia slightly shake her head yes/no. Knowing today is Wednesday, the babysitter reaches into Sofia's backpack to retrieve the note from the teacher. Sofia cringes as her babysitter sighs and hangs it on the fridge for her parents to find when they return from work. "This behavior needs to stop," her babysitter thinks, "I know she is shy, she always has been, but still, the kid barely talks."

Sofia finishes her homework and points to the back door. "Go ahead and go out, but next time please use your words like a big girl," the babysitter answers. Sofia rises from her chair and darts out the door towards the swing set. She climbs on her swing and begins to pump her legs as she quietly sings to herself. She hears the garage door opening and knows that her mom is home from work. Sofia jumps from the swing and runs to meet her mother. "MOMMY," she squeals and gives her mother a big hug. "How was school, sweetie?" her mother asks. Sofia

shrugs her shoulders and falls silent knowing that as soon as her mom walks in the house she will see the note from her teacher hanging on the fridge. Sofia begins to think about how she wants to talk to people, but sometimes the words just get stuck. She just holds her mother's hand as they enter the house.

Unfortunately, many children find themselves in similar situations and like Sofia; their behavior may be classified as defiant. In reality, these children are *not* choosing to *not* speak, but instead are suffering from a disorder known as selective mutism.

### **Selective Mutism**

"Selective mutism is an anxiety disorder, characterized by a lack of verbal (and sometimes nonverbal) communication in specific settings," (Kotrba, 2014, p. 2). The disorder is thought to impact the body's ability to regulate signals sent by the amygdala (Kotrba, 2014). The amygdala regulates portions of the sympathetic nervous system including the fight or flight response, a natural reaction to fear or danger. "More recently, clinicians have added a third fear response — to freeze," (Mac, 2016 ). This response prepares the body to deal with potential hazards.

Not all instances that the body initially perceives as a threat turn out to be dangerous, such as jumping while watching a scary movie. The person is in no immediate danger, but the body responds as if the danger is real, he/she may jump and his/her heart may start racing. The body will come to realize that the perceived threat is not really a threat at all and begin to return to its resting state. Problems arise if the body remains in this state of fear when there is no impending danger, this can lead to the development of phobias and is a contributing factor to selective mutism (Mac, 2016).



Selective mutism affects approximately 1 in every 100 elementary students, a similar prevalence to autism and is diagnosed in girls about twice as frequently as in boys (Kotrba, 2014). There are theories as to the reasoning for the discrepancy between genders, but as of yet there is no definitive answer. Selective mutism is often diagnosed around 2.7 to 4.1 years of age, when onset of symptoms occur, but may persist into adulthood (Kotrba, 2014). Bilingual children also have a higher incidence of selective mutism, "[t]hese findings likely are due to misdiagnoses" (Busse & Downey, 2011, p. 56). In the case of bilingual children, lack of confidence with a second language is not thought to be the cause of selective mutism, as the mutism commonly will regress to the child's first language (Kotrba, 2014).

Researchers suggest a possible genetic component, as most individuals diagnosed with selective mutism have one or more parents who suffer from anxiety disorders, such as obsessive compulsive disorder, general anxiety, and/or selective mutism. Many children with selective mutism have siblings with similar disorders, and this is especially common in identical twins (Kotrba, 2014). It is not uncommon for a child with selective mutism to have multiple diagnoses involving anxiety related disorders including social phobia (e.g., Kotrba, 2014; Schum, 2002). "Research has shown that a person with anxiety experiences a hypertrophy in the volume of neurons in the amygdala, heightening fear responses and causing an overactive amygdala," (Mac, 2016 ). This discovery could be used to explain the incidence of children with multiple anxiety related diagnoses by highlighting a common characteristic among selective mutism and other anxiety disorders.

**Diagnosing Selective Mutism**

An official diagnosis must be made by a clinical psychologist, licensed clinical mental health counselor, clinical social worker, psychiatric nurse, speech/language pathologist, or physician (such as a pediatrician or psychiatrist) (Kotrba, 2014). Despite the various and abundant professionals who can diagnose the disorder, the prevalence of children diagnosed with selective mutism is likely to be inaccurate due to the numerous individuals with selective mutism who maybe misdiagnosed as having other disorders such as, general anxiety or autism, or not diagnosed at all. Many individuals who are thought to have selective mutism are never diagnosed and do not receive proper treatment. To more effectively diagnose selective mutism, the *Diagnostic and Statistical Manual of Mental Disorders 5* (DSM-5) guidelines for diagnosis of selective mutism include:

**"A.** Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.

**B.** The disturbance interferes with educational or occupational achievement or with social communication.

**C.** The duration of the disturbance is at least 1 month (not limited to the first month of school).

**D.** The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

**E.** The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder." (American Psychiatric Association, 2013, p. 233).

This definition encompasses all criteria for diagnosis and serves as a way to distinguish selective mutism from other disorders that may have some similar characteristics to help prevent misdiagnosis. The above definition distinguishes selective mutism from autism because even though, selective mutism and autism can have similar symptoms, including poor eye contact and awkward/stiff body postures, symptoms of selective mutism are only present in specific situations where the child is uncomfortable or anxious, whereas symptoms of autism spectrum disorders occur in all environments. The criteria listed in the DSM-5 also helps to distinguish children with selective mutism from children who have a shy temperament by stating that the symptoms must persist for at least one month or six months if in the first year of school. This excludes children with shy temperaments because they commonly warm up to new situations after a given period of time to adjust, whereas children with selective mutism will not (Kotrba, 2014).

Unfortunately "[s]elective mutism is an anxiety disorder and currently one of the most misunderstood, underdiagnosed and undertreated conditions in mental health," (Mac, 2016 ), this problem may exist for several reasons. First, limited research of the disorder and its implications has been completed and there is much that is still unknown. Second, many professionals involved with diagnosing selective mutism have limited to no experience with the disorder and may not be as quick to diagnosis it. Another factor that hinders the diagnosing process is that many children, especially when entering school, go through a shy phase. Therefore, selective mutism may often be mistaken for shyness and it is a common practice to use the "wait and see" method in hopes that the child may "come out of his/her shell." So, even if variations in a child's communication are known, these differences are not seen as abnormal and it becomes unlikely that anything will be done to remedy the sit



uation. Children with selective mutism do not commonly “grow out of it” and during this time the child typically develops a pattern of avoidance of social interactions, which later becomes difficult to break. A final contributing factor to the under diagnosis of selective mutism is that many individuals may not know it is a problem. Variation in the amount and type of communication a child expresses across the different environments the child is exposed to can lead to the dangerous assumption that the child’s interactions in multiple environments are consistent in nature. The child may be thought to be social in school if they are social at home, to be shy at home if they are shy in school, etc. If these discrepancies in communication are not discovered and assessed, individuals are not inclined to seek treatment. These children may “slip through the cracks” if the cycle, as illustrated in Figure 1, is not broken.



**Figure 1. Process of non-diagnosis.** This figure illustrates a cyclical pattern in which the child may not be diagnosed and therefore may not receive treatment for his/her selective mutism due to unknown symptoms.

### History of Selective Mutism

Selective mutism was originally thought of as a voluntary decision due to a traumatic episode in the child's life or due to neglectful and/or abusive parental relationships. It was



named "aphasia voluntaria" by the German physician, Adolph Kussmaul in 1877. In 1934, the disorder was renamed "elective mutism" by Mortiz Tramer and the mentality that the individuals were electing not to communicate remained. It was not until 1994 that the name was changed to selective mutism due to the mutism's appearance in select situations. Researchers uncovered that this condition was not in fact a choice, but rather individuals were unable to communicate due to anxiety experienced in specific environments (Kotrba, 2014).

Researchers are now suggesting that there are three subsets of selective mutism, which include anxious, anxious/communication-delayed, and anxious/oppositional. "[E]xclusively 'anxious' children with selective mutism, demonstrate freezing behavior, difficulty with both nonverbal and verbal responding and initiating, and significant social anxiety," (Kotrba, 2014, p. 12). This subset is thought to be the smallest and individuals who fit into this category tend to have the lowest levels of symptom severity. The anxious/communication-delayed subset is characterized by a presence of a mild to severe communication delay in addition to significant social anxiety. "In research, they score higher than the exclusively anxious group in symptom severity and behavioral issues, suggesting that overall this group may be the most severely impaired, and therefore the most complex to treat," (Kotrba, 2014, p. 12). The anxious/oppositional subset is characterized by defiant behavior including, running, active avoidance, stubbornness and/or controlling behavior when prompted to speak. As of yet it is unclear whether this behavior is the result of anxiety or a comorbid symptom separate from selective mutism (Kotrba, 2014).

Selective mutism occurs on a spectrum with a wide range of severities from mild to severe. Although all children diagnosed with selective mutism have impaired communication, the impairment may affect verbal and/or nonverbal communication to various degrees. Some

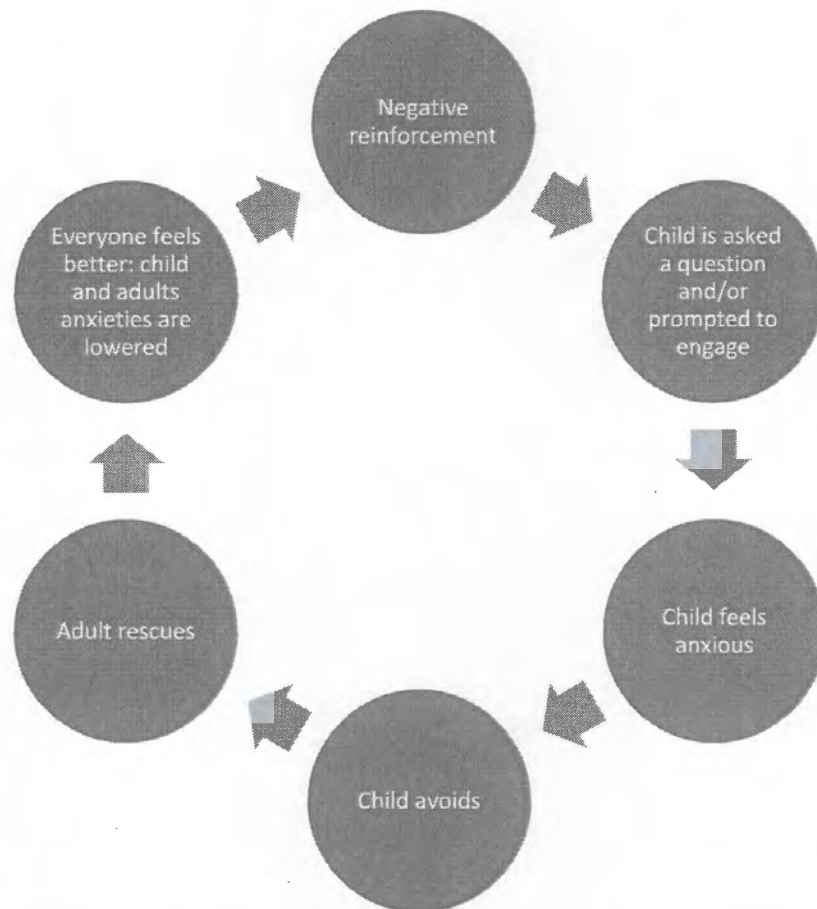
individuals may not be able to talk in front of class, but have no problems talking to others individually. Others may communicate with peers but not with adults and vice versa. For other children, their selective mutism is so severe that they may find themselves unable to even communicate nonverbally, by shaking their heads or pointing. Still other children are able to communicate verbally but only in whispered voices or may use "whisper partners," by whispering to another individual and having this person speak aloud for the child (Kotrba, 2014).

Selective mutism may manifest itself differently in each individual but there are traits that are common to most children with selective mutism. As mentioned before individuals with selective mutism have difficulties with communication in specific environments, in these environments it is common for children to have difficulty responding and initiating verbally as well as difficulty communicating nonverbally. These children tend to have average to above-average intelligence and may be described as perceptive and sensitive. When anxious these individuals may exhibit freezing and/or awkward body movements such as stiffness, tense shoulders, strained facial expressions, etc. They tend to have poor eye contact and are often slow to respond when asked questions. It is also thought that about 75% of children with selective mutism have a hearing difference in which they are unable to hear others when speaking and so must choose between speaking or listening (Kotrba, 2014).

### **Causes of Selective Mutism**

As of yet a definitive cause of selective mutism has not been discovered. Previously it was thought that all incidences of selective mutism were the result of a traumatic event, but this theory has since been proven incorrect. It is now believed that there is a genetic component to at least some instances of selective mutism because of its tendency to manifest itself in individuals

with familial history of anxiety disorders and currently is located under social phobias in the DSM-5 (Kotrba, 2014).



**Figure 2. Learned cycle of avoidance.** This figure illustrates the cyclical process in which the behavior of avoiding communication is learned.

In order to cope with the selective mutism a pattern of avoidance tends to develop into a cycle as illustrated in Figure 2. Often when a child with selective mutism is prompted to speak in a situation that causes him/her to feel anxious, the child will avoid communication. This avoidance deviates from social norms and typically causes others involved to become anxious as well. In order to remedy the situation, it is common for individuals who know the child, such as



parents, teachers, siblings, peers, etc, to "rescue" the child from the situation. This can be done by speaking for the child or saying comments like "Oh s/he is just shy" or "S/He doesn't talk much." By rescuing the child, all involved feel a sense of relief, as the awkward pause is filled and the expectation of the child to communicate has been removed. This "rescuing" then becomes reinforced, as the unwanted feeling of anxiety is reduced for everyone involved. Due to the reinforcement it becomes more likely that the child will avoid communication, other individual/s will speak for the child, and expectations of the child to communicate are often reduced in the future. Although "rescuing" the child provides temporary relief, it allows the vicious cycle to become a habit, often making future treatment more difficult.

### **Treatments**

Due to the heterogeneity of the population diagnosed with selective mutism there is not one set treatment plan, rather each plan is tailored to the individual and the methods that best suits his/her needs. This is not an exhaustive list, but many of the treatment methods used with selective mutism fall under one of the following three categories; behavioral and cognitive-behavioral therapy, medication, and individual psychotherapy. Below is a brief summary of each of these three approaches, which are also outlined in Figure 3. It is important to note that methods from each of these categories may be combined in a multi-method approach to treat selective mutism (Busse & Downey, 2011).

**Behavioral and cognitive-behavioral therapy.** Researchers have shown that behavioral and cognitive-behavioral therapy tend to be the most successful and thus far have most research to support its usage (Busse & Downey, 2011). This treatment method includes: contingency management, shaping, social skills training, stimulus fading, systematic desensitization,

relaxation training, and self-modeling. For the purpose of brevity this section will focus on stimulus fading, systematic desensitization and shaping (Busse & Downey, 2011).

Stimulus fading involves altering the child's environment. It starts with a person or people the individual is most comfortable with and involves a gradual introduction of individuals with whom the child is less comfortable with, while slowly removing initial person/persons. The next type is systematic desensitization which "is the process of gradually exposing a person to a hierarchy of anxiety-provoking stimuli, with the goal of reducing the person's level of anxiety in each situation," (Busse & Downey, 2011, p.60 ). For this method it is important to start with a situation that produces minimal anxiety, such as whispering to one person and very gradually work up to more stressful situations (Busse & Downey, 2011).

"Once these children's environments are controlled with antecedent management, their behaviors are shaped with successive approximations, working toward an incentive in which they are positively reinforced through operant conditioning and they have the psychoeducational skills to reduce their anxiety," (Mac, 2016).

This type of therapy may use a variety of methods to elicit desired response including musical instruments. When using music therapy, the individual is introduced to a musical instrument, commonly a recorder or drums, and the instrument is used as a way of expression without demands for speech. As time passes and the child is more comfortable with the instrument, the therapist may use another instrument to have musical conversations with the child, in which the therapist and child respond in similar ways as speech with his/her instrument. These musical conversations practice skills necessary in normal communication, such as turn taking and pauses. Over time the instrument is slowly removed as the child works towards more speech-like productions, until the final goal of verbal exchanges is met (Busse & Downey, 2011).

**Medication.** When treating selective mutism pharmacologically, there are two common types of medications used, benzodiazepines and selective serotonin re-uptake inhibitors (SSRI).

"So in the case of SM [selective mutism] where non-pharmacological, psychological, speech and language therapy and educational measures are either not working or are only partially effective through the presence of handicapping degrees of anxiety for any given individual and after specific anxiety-reducing psychological therapies (such as relaxation and cognitive behavioral therapy) have been tried, consideration of anxiety-reducing medication is commonly the next step," (Jemmett et al., 2014, p. 133).

Benzodiazepines work by enhancing the action of a GABA, a neurotransmitter, which helps to rapidly reduce anxiety. This medication is not recommended for long term usage, lasting more than four to six weeks, as it can produce tolerance and dependence.

Benzodiazepines are prescribed for intermittent usage and are taken before a person knows he/she will be placed in an anxiety filled situation, for example a person may take benzodiazepine before an exam or before giving a speech (Jemmett et al., 2014).

The second type of medication commonly prescribed to individuals with selective mutism are selective serotonin re-uptake inhibitors (SSRIs). The most common SSRI is fluoxetine, but others include citalopram and sertraline substitutes for fluoxetine. As of yet, researchers are unsure of how SSRIs work, but know they boost the body's supply of serotonin. Selective serotonin re-uptake inhibitors are able to be taken long term but "it [fluoxetine] should never be seen as a complete panacea, but it can help to create the conditions where progress can begin to be made." (Jemmett et al., 2014, p. 130).



**Individual psychotherapy.** Psychotherapy is used "to help reduce the general anxiety and to practice better communication skills," (Schum, 2002, p. 4). It often focuses on anxiety; in which the child and therapist may talk about being brave versus nervous (Schum, 2002). One type of individual psychotherapy is the play interaction approach, which "provide[s] the children with a relaxed, fun and motivating environment, free from direct demands or pressures to speak" (Jemmett et al., 2014, p. 147). "When appropriate the sessions are generalized with familiar people/peers in other social settings," (Jemmett et al., 2014, p. 141), but must be done at the child's pace.

Behavioral and Cognitive-Behavioral Therapy	<ul style="list-style-type: none"> <li>• <b><u>Self-modeling</u></b> <ul style="list-style-type: none"> <li>• "involves using a video or audio device that records the child speaking, and then inserting the recording into an environment in which the child typically does not speak" (Busse &amp; Downey, 2011, 60)</li> </ul> </li> <li>• <b><u>Stimulus Fading</u></b> <ul style="list-style-type: none"> <li>• start with person/people most comfortable with and gradual introduce individuals with whom the child is less comfortable with and slowly removing initial person/persons</li> </ul> </li> <li>• <b><u>Systematic desensitization</u></b> <ul style="list-style-type: none"> <li>• "is the process of gradually exposing a person to a hierarchy of anxiety-provoking stimuli, with the goal of reducing the person's level of anxiety in each situation" (Busse &amp; Downey, 2011, p.60 )</li> </ul> </li> <li>• <b><u>Operant Conditioning</u></b> <ul style="list-style-type: none"> <li>• usage of successive approximations to encourage appropriate communication</li> </ul> </li> </ul>
Medications	<ul style="list-style-type: none"> <li>• <b><u>Benzodiazepines</u></b> <ul style="list-style-type: none"> <li>• "a short term medication used to reduce anxiety by enhancing the action of the brain chemical GABA" (Busse, &amp; Downey, 2011, p. 134)</li> </ul> </li> <li>• <b><u>Selective serotonin re-uptake inhibitors (SSRI)</u></b> <ul style="list-style-type: none"> <li>• a longer term medication used to reduce anxiety by boosting supply of serotonin (Busse &amp; Downey, 2011)</li> </ul> </li> </ul>
Psychotherapy	<ul style="list-style-type: none"> <li>• to help reduce the general anxiety and to practice better communication skills; and a behavioral program at school to slowly shape increasingly appropriate communication. (Jemmett, et al., 2014)</li> </ul>
Multi-method approach	<ul style="list-style-type: none"> <li>• Any combination of treatment approaches (Busse, Downey, 2011)</li> </ul>

**Figure 3. Common treatment methods for selective mutism.** This figure outlines different methods that may be used in treatment of a child with selective mutism, including a brief description of each type.

**Conclusion**

The population of children diagnosed with selective mutism is thought to be increasing, however, "[e]stablishing accurate incidence and prevalence rates is hampered by the different levels of severity and common misdiagnoses of children with SM [selective mutism]," (Schum, 2002, p. 56).

As the prevalence of the disorder rises, it is important that individuals who interact with these children begin research and learn the most effective ways to help the child overcome this disorder. Currently, research on selective mutism is limited, but behavioral and cognitive-behavioral therapy methods are being tested for effectiveness in regards to selective mutism. Additional research is needed in many areas of selective mutism, especially its cause/s. If researchers were able to uncover the cause of selective mutism, the probability of researchers also developing more effective screening and diagnostic tools will increase. Also, discovering the cause of selective mutism could lead to possible prevention methods for children who are at risk of developing the disorder.

"It's also important to understand that most of these children desperately *want* to be able to speak to others, but they are unable to do so because their fear creates an inability to speak in that moment," (Mac, 2016 ). Identifying children who suffer from selective mutism is of upmost importance to ensure early intervention, therefore, knowledge of the disorder and its symptoms are key.



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## Tips for the home

- Do not use threats or punishments to get the child to talk.
- Instill hope in the child, reassuring them that there is help and they can overcome their situation.
- Allow your child to find pleasure in activities, outside the home to practice their strengths and foster self-esteem.
- Provide opportunities for your child to interact with peers and form meaningful relationships.
- Keep bringing different peers into the home (one or two at a time) and follow step 1 above to generalize communication to other places and people. Once a peer group has been established, consider having the play-dates at the other child's home.
- When taking the child to social activities, arrive early, allow the child time to 'check out the environment' feel comfortable, and slowly warm up. Do not force them to interact or play.
- The biggest challenge as a parent is knowing when to "push the child" and when to let go. You want to provide opportunities for socialization and not reward isolation and withdrawal. This is done in a slow and caring manner (Coiffman-Yohros, 2016).

## Tips for the home (continued)

- Role-play situations that are anxiety provoking at home. This will help you understand their difficulty as well as giving them social skills.
- Provide plenty of praise and social rewards for communication.
- Seek advice and help from professionals in your area.
- Teach the child relaxation techniques, positive imagery and incorporate physical activity into their daily routine. This will help reduce the anxiety.
- Establish a support network for you as a parent. Children perceive their parents anxiety and frustration. *Take care of yourself so you can care for your child* (Coiffman-Yohros, 2016).

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# Selective Mutism

For parents of children with selective mutism

HALEY FLEDDERJOHANN AND DR. JULIE GRIFFITH



## What is it?

**Selective mutism** is a communicative disorder in which the child is able to communicate in some environments , but is unable or has limited communication in others. In order to be diagnosed with selective mutism the child must meet the following criteria as defined by the *Diagnostic Statistical manual Mental Disorders 5; (DSM-5)*;

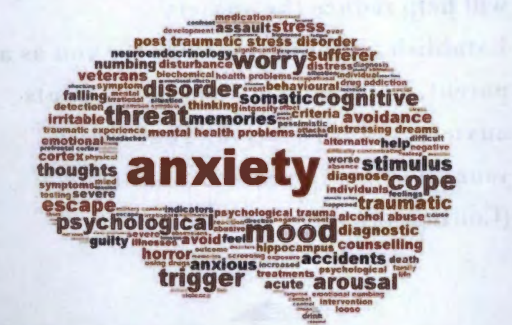
- A.** Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
- B.** The disturbance interferes with educational or occupational achievement or with social communication.
- C.** The duration of the disturbance is at least 1 month (not limited to the first month of school).
- D.** The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E.** The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder." (American Psychiatric Association, 2013, p. 233).

## Common Myths:

**Myth 1**— Children with selective mutism are choosing not to speak.

**Myth 1—**Children with selective mutism are choosing not to speak.

**Reality-** "[O]nce a person with selective mutism comes into contact with someone else, his or her autonomic nervous system — specifically the sympathetic nervous system — is activated with the fight, flight or freeze response, signifying extreme danger...It's also important to understand that most of these children desperately *went* to be able to speak to others, but they are unable to do so because their fear creates an inability to speak in that moment." ( Mac, 2016).



**Myth 2—**Selective mutism is caused by a traumatic event in the child's past.

**Reality**— This theory has been proven false, but as of yet a definitive cause has not been discovered, but research is indicating a possible genetic component due to indications of a familial trend relating to anxiety disorders (Kotrba, 2014).

**In addition to the criteria listed by the DSM-5, warning signs of selective mutism include a child who;**

1. Often has difficulty maintaining eye contact.
2. Often is reluctant to smile and oftentimes will have blank facial expressions. Often has stiff or awkward body movements
3. May have a tendency to worry more about things than other people do.
4. Often is extraordinarily sensitive to noise, crowds and crowded situation.
5. Oftentimes has frequent temper tantrums at home.
6. Often will appear to be excessively shy when in reality they actually have a fear of people and will cling to caretaker when young.
7. May also have an anxiety disorder such as social phobia.
- For more information visit [selectivemutismfoundation.org](http://selectivemutismfoundation.org)

**\*SYMPTOMS LISTED ABOVE ARE INDICATIVE OF SELECTIVE MUTISM BUT SHOULD NOT BE USED AS A MEANS FOR DIAGNOSIS.. A DIAGNOSIS MUST BE MADE BY QUALIFIED PROFESSIONAL.\***



## Tips for the classroom

- Ensure that all adults in the child's life are aware of his/her difficulty and have up-to-date information about the disorder
- Decrease the anxiety, by not forcing the child to speak, keeping the child in regular mainstream classes, giving opportunities for activities that do not require spoken language, and allowing the child to have a buddy system and participate in small group activities.
- "Allow the child to communicate in another way
  - ◇ For example by symbols, gestures, cards, e mail.
  - ◇ For verbal reports, the child may tape themselves at home and then bring the tape to the school.
- Use a peer that the child talks to in the class as a bridge for initial communication and for need situations, such as restroom use or medical needs.
- As much as possible, make sure the child is always included in teams and group activities, regardless of verbal communication.
- Keep schedule as consistent as possible, and advise the child in advance of any changes in routine or classroom activities.
- Keep the child in the same small groups for classroom work. Switching partners frequently is not recommended.
- Be consistent and provide a "firm-loving" hand.
- Provide plenty of praise for any sound or attempt at communication the child makes." (Coiffman-Yohros, 2016).

## How to help

Referral to either a clinical psychologist, licensed clinical mental health counselor, clinical social worker, psychiatric nurse, speech/language pathologist, or physician (such as a pediatrician or psychiatrist) (Kotrba, 2014) to make a diagnosis should be the first step taken to help the child.

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# Selective Mutism

For teachers of children with selective mutism

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## What is it?

Selective mutism is a communicative disorder in which the child is able to communicate in some environments , but is unable or has limited communication in others. In order to be diagnosed with selective mutism the child must meet the following criteria as defined by the *Diagnostic Statistical manual Mental Disorders 5; (DSM-5)*;

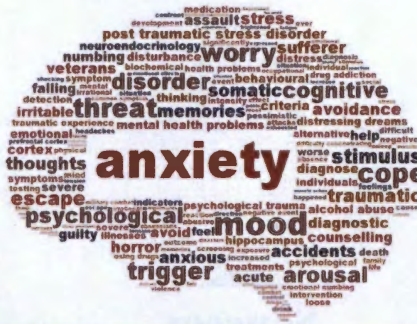
- A.** Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
- B.** The disturbance interferes with educational or occupational achievement or with social communication.
- C.** The duration of the disturbance is at least 1 month (not limited to the first month of school).
- D.** The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E.** The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder." (American Psychiatric Association, 2013, p. 233).

## Common Myths:

**Myth 1**— Children with selective mutism choosing not to speak.

**Myth 1—**Children with selective mutism are choosing not to speak.

**Reality-** "[O]nce a person with selective mutism comes into contact with someone else, his or her autonomic nervous system — specifically the sympathetic nervous system — is activated with the fight, flight or freeze response, signifying extreme danger...It's also important to understand that most of these children desperately *want* to be able to speak to others, but they are unable to do so because their fear creates an inability to speak in that moment." ( Mac, 2016).



**Myth 2—**Selective mutism is caused by a traumatic event in the child's past.

**Reality**— This theory has been proven false, but as of yet a definitive cause has not been discovered, but research is indicating a possible genetic component due to indications of a familial trend relating to anxiety disorders (Kotrba, 2014).

**In addition to the criteria listed by the DSM-5, warning signs of selective mutism include a child who;**

1. Often has difficulty maintaining eye contact.
2. Often is reluctant to smile and oftentimes will have blank facial expressions. Often has stiff or awkward body movements
3. May have a tendency to worry more about things than other people do.
4. Often is extraordinarily sensitive to noise, crowds and crowded situation.
5. Oftentimes has frequent temper tantrums at home.
6. Often will appear to be excessively shy when in reality they actually have a fear of people and will cling to caretaker when young.
7. May also have an anxiety disorder such as social phobia.
- For more information visit [selectivemutismfoundation.org](http://selectivemutismfoundation.org)

**\*SYMPTOMS LISTED ABOVE ARE INDICATIVE OF SELECTIVE MUTISM BUT SHOULD NOT BE USED AS A MEANS FOR DIAGNOSIS.. A DIAGNOSIS MUST BE MADE BY QUALIFIED PROFESSIONAL.\***